VERMILION PARISH SCHOOL BOARD HIGH DEDUCTIBLE HEALTH PLAN

SCHEDULE OF BENEFITS

PLAN NAME		GROUP NUMBER
Vermilion Parish School Board High Deductible Health Plan (HDHP)		78K22ERC
PLAN'S ORIGINAL BENEFIT PLAN DATE	**PLAN'S AMENDED BENEFIT PLAN DATE**	**PLAN'S ANNIVERSARY DATE**
June 1, 2016	January 1, 2019	January 1st

BENEFIT PERIOD:	Calendar Year - January 1 through December 31

DEDUCTIBLE AMOUNTS:	
NETWORK PROVIDERS	
Individual:	$3,300
Family:	$6,600
Per Member within a Family:	$6,600
NON-NETWORK PROVIDERS	
Individual:	$6,600
Family:	$13,200

SPECIAL NOTES:

If the Benefit Plan includes more than one (1) member, the Individual Deductible Amount is not applicable. The Family Deductible Amount and Per Member within a Family Deductible Amount applies.

Benefits for services of Network Providers that accrue to the Deductible Amount for Network Providers WILL NOT accrue to the Deductible Amount for Non-Network Providers.

Benefits for services of Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL NOT accrue to the Deductible Amount for Network Providers.

Benefits for Emergency Services of Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL ALSO accrue to the Deductible Amount for Network Providers.

The Benefit Period Deductible Amount does not apply to the following:

- Preventive or Wellness Care (All Providers)

OUT-OF-POCKET AMOUNT – Includes the Benefit Period Deductible Amount.	
NETWORK PROVIDERS	
Individual:	$6,350
Family:	$12,700
Per Member within a Family:	$6,850
NON-NETWORK PROVIDERS	
Individual:	$12,700
Family:	$25,400

SPECIAL NOTES:

Benefits for services of a Network Providers that accrue to the Out-of-Pocket Amount for Network Providers WILL NOT accrue to the Out-of-Pocket Amount for Non-Network Providers.

Benefits for services of Non-Network Providers that accrue the Out-of-Pocket Amount for Non-Network Providers WILL NOT accrue to the Out-of-Pocket Amount for Network Providers.

Benefits for Emergency Services of Non-Network Providers that accrue to the Out-of-Pocket Amount for Non-Network Providers WILL ALSO accrue to the Deductible Amount for Network Providers.

MEDICAL BENEFITS – COINSURANCE:		
	NETWORK PROVIDERS	**NON-NETWORK** **All Other Providers**
Coinsurance shown as Company - Plan Participant responsibility. Deductible must be met prior to Coinsurance, except as specified as waived.		
Inpatient and Outpatient Services:	70% - 30%	50% - 50%
Office Visits:	70% - 30%	50% - 50%
Inpatient Hospital Admission: Includes Facility and Professional / Physician Services.	70% - 30%	50% - 50%
Accidental Injuries: Limited to Dental Services - Accident Only	70% After the Deductible	70% After the Deductible
Emergency Medical Services – performed in the Emergency Department of a Hospital: Includes Facility and Professional/Physician Services.	70% - 30%	70% - 30%
Emergency Ambulance Services:	70% - 30%	70% - 30%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes Facility and Professional / Physician Services.	70% - 30%	50% - 50%
Dietitian Visits:	70% - 30%	50% - 50%

MEDICAL BENEFITS – COINSURANCE CONT'D:		
Hearing Aid Benefits:		
Ages 17 and under • Limited to a (1) one purchase (including repair/replacement) per hearing impaired ear every (3) three years. Ages 18 and up • Limited to $2,500 per Plan Participant each Benefit Period. • Limited to a (1) one purchase (including repair/replacement) per hearing impaired ear every (3) three years.	70% - 30%	50% - 50%
Home Health Care: Limited to 180 visits per Plan Participant each Benefit Period.	70% - 30%	50% - 50%
Hospice Care:	70% - 30%	50% - 50%
Mental Health and Substance Use Disorders: Outpatient Mental Health and Substance Use Disorder Benefits (Includes Office Visits, Outpatient Facility and Outpatient Therapies)	70% - 30%	50% - 50%
Inpatient Mental Health and Substance Use Disorder Benefits (Includes Facility and Professional / Physician services)	70% - 30%	50% - 50%
Organ, Tissue, and Bone Marrow Transplants: Authorization required prior to services being performed.	70% - 30%	50% - 50%
Pregnancy Care: See the "Pregnancy Care and Newborn Care" Article for more details on Pregnancy Care and Newborn Care Benefits.	70% - 30%	50% - 50%
Preventive or Wellness Care: See the "Preventive or Wellness Care" Article for more details on Preventive or Wellness Care Benefits.	100% Deductible Waived	50% - 50% Deductible Waived
X-rays, Lab Tests, Machine Tests, and High-Tech Imaging:	70% - 30%	50% - 50%
Rehabilitative Care Services: • Physical and Occupational Therapy • Speech Therapy • Chiropractic Services: Limited to 20 visits per Plan Participant each Benefit Period. • Cardiac Rehabilitation: Limited to 36 visits per Plan Participant each Benefit Period.	70% - 30%	50% - 50%
Skilled Nursing Facility: Limited to 90 days per Plan Participant each Benefit Period.	70% - 30%	50% - 50%
Urgent Care Center:	70% - 30%	50% - 50%
Vision Care Exam: Limited to 1 in a 24-month period per Plan Participant.	70% - 30%	Not Covered

PRESCRIPTION COVERAGE:	
Prescription Deductible Amount – per Plan Participant:	$3,300
Prescription Family Deductible Amount – per family unit:	$6,600
Prescription Deductible is combined with Medical Benefit Period Deductible.	
Prescription Coinsurance:	**RETAIL OR MAIL**
Coinsurance shown as Company-Member responsibility.	
Generic Drugs:	70% - 30%
Brand-Name Drugs:	50% -50%
Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.	
Dispensing Limitation per Prescription or Refill:	
Retail:	Up to a ninety (90) day supply
Retail- Maintenance Drugs:	Up to a thirty (30) day or ninety (90) day supply
Mail Order:	Up to a ninety (90) day supply
Specialty Drugs:	Limited to a thirty (30) day supply
Prescription Drug Step Therapy	
Certain drugs and/or drug classes are subject to Step Therapy. In some cases, the Plan Participant may be required to first try one or more Prescription Drugs to treat a medical condition before the Plan will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Plan Participant's medical condition, the Plan Participant's Physician may be required to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Plan will cover a prescription written for Drug B. However, if Your physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B Drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.	
Categories of Prescription Drugs that require Step Therapy - As these categories may change from time to time, the Plan Participant may wish to call the customer service number on their ID card or check the website at **www.bcbsla.com/pharmacy** to determine what categories of Prescription Drugs are subject to step therapy: Examples may include but are not limited to the following:	
• Blood Pressure Medications: (example: Angiotensin Converting Enzyme Inhibitors, Angiotensin II Receptor Blockers, Direct Renin Inhibitors)	
• Pain Medications: (example: Non-Steroidal Anti-Inflammatory Drugs, COX-2 Inhibitors)	
• Cholesterol Medications: (example: HMG-CoA Reductase Inhibitors)	
• Sleep Medications: (example: Sedatives, Hypnotics)	
• Stomach Acid Medications: (example: Proton Pump Inhibitors)	
• Respiratory/Allergy Medications: (example: Nasal Antihistamines, Non-Sedating Antihistamines, Nasal Steroids)	
• Depression Medications: (example: Selective Serotonin Reuptake Inhibitors, Serotonin/Norepinephrine Reuptake Inhibitors)	

Categories of Prescription Drugs that Require Prior Authorization:
The following categories of Prescription Drugs require prior Authorization. The Plan Participant's Physician must call 1-800-842-2015 to obtain the Authorization. The Plan Participant can call the customer service number on the back of his ID card or check at **www.bcbsla.com/pharmacy** to determine what categories of Prescription Drugs require prior authorization.
Specialty Drugs – Examples may include, but are not limited to:
• Growth hormones*
• Anti-tumor necrosis factor drugs*
• Intravenous immune globulin*
• Interferons
• Monoclonal antibodies
• Hyaluronic acid derivatives for joint injection*
• Proprotein convertase subtilisin/kexin type 9 (PCSK-9) inhibitors (e.g. Praluent®, Repatha™)*
* Shall include all drugs that are in this category.
Compound Drugs over $100.00.
Traditional drugs that are not considered to be Specialty Drugs, are typically self-administered, and commonly dispensed by retail pharmacies. Examples may include but are not limited to: Provigil®, Nuvigil®, Symlin®, Byetta®, Victoza®
Controlled Dangerous Substances – Examples may include, but are not limited to: Actiq®, OxyContin®
Therapeutic/Treatment Vaccines – Examples include, but are not limited to vaccines to treat the following conditions: Allergic Rhinitis, Alzheimer's Disease, Cancers, Multiple Sclerosis, and Substance Use Disorder.

CARE MANAGEMENT
Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling **1-800-376-7973.** If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, the Plan will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary. If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Plan Participant must pay all charges incurred. If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services.
Authorization of Inpatient and Emergency Admissions:
Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information. If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for the applicable Deductible Amount and Coinsurance percentage. NOTE: Benefits for Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits. If a Non-Network Provider fails to obtain a required Authorization, services and/or supplies will not be covered and the Plan Participant must pay all charges incurred.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:
If Authorization is not requested prior to a listed service or supply being rendered, the Plan Participant's claim may be reviewed for Medical Necessity. If it was Medically Necessary, Benefits will be provided based on the Network status of the Provider of the service or supply. If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all services and supplies requiring an Authorization. The Network Provider is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage. Additional Network Provider responsibility if Authorization is not requested for Outpatient services and supplies furnished by a Non-Network Provider: **30% reduction of the Allowable Charges.** If a Non-Network Provider fails to obtain a required Authorization, services and/or supplies will not be covered and the Plan Participant must pay all charges incurred.
The following services and supplies require Authorization prior to the services being rendered or supplies being received.
• Air Ambulance – Non-Emergency (no Benefit without prior Authorization)
• Applied Behavior Analysis
• Bone Growth Stimulator
• Cardiac Rehabilitation
• CT Scans
• Day Rehabilitation Programs
• Dialysis
• Durable Medical Equipment (Greater than $300.00)
• Electric & Custom Wheelchairs
• Home Health Care
• Hospice Care
• Hyperbarics
• Implantable Medical Devices over $2,000.00, (including but not limited to defibrillators and insulin pumps)
• Infusion Therapy not performed in a Physician's office, other than chemotherapy
• Intensive Outpatient Programs
• MRI / MRA
• Nuclear Cardiology
• Orthotic Devices (greater than $300)
• Outpatient pain rehabilitation or pain control programs
• Partial Hospitalization Programs
• PET Scans
• Prosthetic Appliances
• Residential Treatment Centers
• Sleep Studies(except those performed as a home sleep study)
• Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
• Transplant Evaluation and Transplants
• Vacuum Assisted Wound Closure Therapy

ELIGIBILITY WAITING PERIOD
The Plan Administrator will determine the Eligibility Waiting Period and Effective Date of coverage for all eligible Employees and their Dependents.
Active Employees: The Eligibility date is the first day of the month following thirty (30) days of employment.
Under no circumstances will the initial Eligibility Waiting Period ever exceed ninety (90) days following the date of hire.